SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Forzinity™ (elamipretide)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

Recommended Dosage: SUBQ: 40 mg once daily

Quantity Limits: 4 vials (14 mL) per 28 days

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial Authorization: 6 months

- ❑ Member is 12 years of age or older
- ❑ Member weighs 30 kg or greater
- ❑ Prescriber is a geneticist, cardiologist, metabolic specialist, hematologist, pediatrician, or a physician who specializes in the treatment of mitochondrial disorder

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- ❑ Member meets **ONE** of the following:
  - ❑ Member is an adult and meets **ONE** of the following **(submit documentation)**:
    - ❑ Member has estimated glomerular filtration rate (eGFR) greater than or equal to 30 mL/min
    - ❑ Member has an eGFR less than 30 mL/min and is **NOT** on dialysis
  - ❑ Member is a pediatric patient and is **NOT** renally impaired
- ❑ Member's diagnosis of Barth syndrome was confirmed by at least **ONE** of the following **(submit documentation)**:
  - ❑ Genetic testing documenting a pathogenic variant in the TAFAZZIN gene [**NOTE: Gene testing must demonstrate a hemizygous pathogenic variant in the TAFAZZIN (TAZ) gene]**
  - ❑ Increased monolysocardiolipin: cardiolipin (MLCL/CL) ratio
- ❑ Provider must submit documentation to confirm member is ambulatory (i.e., able to complete a 6-minute walk test)
- ❑ Provider must submit documentation to confirm the member has functional impairment related to muscle strength (e.g., knee extensor muscle strength measured by handheld dynamometry)
- ❑ Member has **NOT** previously undergone and is **NOT** planned to undergo heart transplantation

Reauthorization: 12 months. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Member continues to meet all initial authorization criteria
- ❑ Member is responding positively to therapy as evidenced by improvement in muscle strength (e.g. knee extensor muscle strength measured by handheld dynamometry) **(submit documentation)**

Medication being provided by Specialty Pharmacy – Proprium Rx

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

***Approved by Pharmacy and Therapeutics Committee**: 1/22/2026
REVISED/UPDATED/REFORMATTED: 2/18/2026